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ABSTRACT

This document is intended to present briefly the needs of children and families, to identify the greatest gaps in services, and to discuss how psychology can mobilize as a profession to address both needs and gaps. It begins by highlighting prominent indicators to demonstrate that America's children and families are in crisis. Following that are a discussion of the needs of children and families, a delineation of essential features of an integrated services system, and a consideration of psychology's role in improving services to children and families. Chapters are: (1) Introduction; (2) American Children and Families in Crisis: A Sampling of Social, Demographic, and Economic Indicators; (3) Needs of Children and Families; (4) An Integrative Perspective on Child and Family Needs; (5) Elements of Service Integration; and (6) Relevance to Psychology. Appendices are: (1) Policy Statement of the American Psychological Association on Psychology and Service Integration; (2) Integrated Services Programs Exemplars; (3) Suggested Reading (16 references); (4) Children's Mental Health Needs: Reform of the Current System; (5) Contributors and Reviewers. (JBJ)

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Comprehensive Coordinated Psychological Services for Children

A Call for Service Integration

Prepared by The Task Force on Comprehensive and Coordinated Psychological Services for Children: Ages 0 to

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Board of Professional Affairs and the Psychology in the Schools Program

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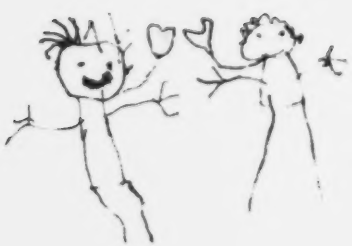
Comprehensive & Coordinated Psychological Services for Children

A Call for Service Integration

Prepared by the Task Force
on Comprehensive and
Coordinated Psychological Services
for Children: Ages 0–10

Board of Professional Affairs and the
Psychology in the Schools Program
American Psychological Association



Adopted as APA Policy August 11, 1994

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Members of the Task Force on Comprehensive and Coordinated Psychological Services for Children (Ages 0–10)

James C. Paavola, PhD, Chair
Memphis (TN) City Schools

Carolyn Cobb, PhD
North Carolina Department of Public Instruction
Raleigh, North Carolina

Robert J. Illback, PsyD
REACH of Louisville (KY), Inc.

Herbert M. Joseph, Jr., PhD
Boston (MA) City Hospital

Ronda C. Talley, PhD
Director, Policy and Advocacy in the Schools,
American Psychological Association

Alicia Torruella, PhD
Private Practice
Phoenix, Arizona

Karen Carey, PhD
California State University at Fresno
Liaison from the National Association of School Psychologists

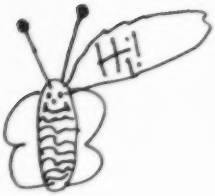
Donald Routh, PhD
University of Miami
Liaison from the Division of Clinical Psychology (Division 12),
American Psychological Association

Roy Martin, PhD
University of Georgia, Athens
Sylvia Rosenfield, PhD
University of Maryland, College Park
Liaisons From the Division of School Psychology (Division 16),
American Psychological Association

John Meier, PhD
San Bernadino (CA) Preschool Services Department
Liaison From the Committee on Children, Youth, and Families,
American Psychological Association

Sylvia Shellenberger, PhD
Medical Center of Central Georgia
Liaison From the Task Force on Rural Psychology,
Amerian Psychological Association

Introduction



Task Force Process

The Task Force on Comprehensive and Coordinated Psychological Services for Children Ages 0–10 (TFCCPS) was established in 1991 by the American Psychological Association's (APA) Board of Professional Affairs and Psychology in the Schools Program on the recommendation of the Task Force on Psychology in the Schools. The mission of the TFCCPS was to assess the current array of services in regard to the psychological and mental health needs of children 0–10, determine gaps in service delivery, and provide recommendations on how these gaps should be addressed.

The five task force members included two clinical psychologists and three school psychologists, with liaisons appointed from APA's Division 12 (Clinical Psychology); Division 16 (School Psychology); the Committee on Children, Youth, and Families; the Task Force on Rural Psychology; and the National Association of School Psychologists.

As numerous documents and resources were identified and reviewed by task force members, it was apparent that comprehensive and integrated services for children and families was a topic of national debate and that psychology was not a visible player in that debate. The Clinton administration health care plan was under development during these deliberations, and the status of mental health services for children, especially preventive care with a developmental

focus, was unclear. As the task force members and liaisons reviewed materials and received information from national experts, the compelling evidence suggested that **psychological services for children could not be comprehensive or coordinated unless they were integrated with a broad range of related services and driven by concern for the needs and desires of families.**

The task force also heard from many other APA committees and staff to determine what activities and initiatives were already underway that might relate to its mission. In 1992, the task force began the development of a conceptual statement on comprehensive and integrated services for children and families. This draft statement was disseminated both within APA and to interested outside groups for feedback. A broad array of organizations was invited to a forum at the April 1993 task force meeting to discuss the concept of service integration and what needs existed, as well as to receive further feedback on the draft document. The large turnout and the discussion revealed high interest and commendations for both the paper and the fact that psychology was interested in this concept. The present document represents the final result of this extensive process.

Format of Service Integration Paper

The current document on service integration should be viewed as a conceptual statement, not a scholarly reference work. A concurrent document is under development to provide a more comprehensive theoretical and empirical foundation for these ideas, especially as they relate to psychology's role. The present document is intended to present briefly the needs of children and families, to identify the greatest gaps in services, and to discuss how psychology can mobilize as a profession to address both needs and gaps. As such, the document begins by highlighting prominent indicators to demonstrate that America's children and families are in crisis. Following that are a discussion of the needs of children and families, a delineation of es-

sential features of an integrated services system, and a consideration of psychology's role in improving services to children and families.

Appendix A contains a policy statement on psychology and service integration, which was approved along with this entire report as official APA policy on August 11, 1994. This resolution is designed to mobilize the psychological community by providing a focus to efforts of the American Psychological Association on behalf of children and families. It also may serve to communicate our goals and intentions to other professional and advocacy groups. Subsequent appendices include (1) a listing of sample programs that seek to integrate comprehensive services (Appendix B); (2) suggested readings for more in-depth information on service integration (Appendix C); (3) a position statement, "Children's Mental Health Needs: Reform of the Current System," developed by the task force in the context of health care reform (Appendix D); and, (4) a listing of invited reviewers of this document (Appendix E).

The task force members hope this conceptual document will initiate further discussion within psychology on how to attain comprehensive psychological services that are coordinated and integrated with other service needs of children and families, that focus on shared goals and outcomes, and that will lead to strengthened, empowered families.

Other Task Force Activities

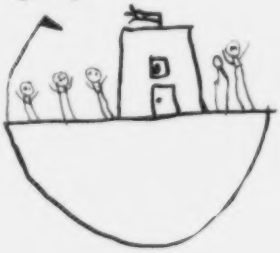
At the April 1993 meeting, Annette Rickel, PhD, an APA Congressional Fellow serving on the mental health subgroup of President Clinton's Health Care Reform Task Force, stated a need for a document addressing children's mental health needs in the context of health care reform. In response, our task force developed the position statement, "Children's Mental Health Needs: Reform of the Current System." This statement emphasizes preventive services, the use of schools and primary health care settings as essential delivery sites,

alternative service approaches, flexible funding arrangements, and mental health services that are integrated with other services and that focus on building competence (see Appendix D).

The task force also was encouraged by APA's Board of Professional Affairs (BPA) to continue the effort to develop a children's agenda for APA. During its final year of work (1993–94), the task force focused on initiating and coordinating dialogue about a comprehensive children's agenda for psychology, integrating existing efforts with proposals for new and expanded initiatives.

American Children and Families in Crisis

A Sampling of Social, Demographic, and Economic Indicators



Economic

• About one in five children lives in poverty. Nearly 25% of children younger than 6 lived in poverty in 1991.

• The median income of young families with children dropped 32% between 1973 and 1990.

• Each year, an estimated 10,000 children die from poverty's effects in the United States.

Health

• The infant mortality rate is higher in this country than in 19 other developed nations.

• Nearly 1 million infants begin life each year without prenatal care.

• Yearly, more than 250,000 babies have a low birth weight.

• There is an epidemic of alcohol and illegal drug use among pregnant women, adversely affecting up to 375,000 babies per year.

• There has been a resurgence in the 1980s of preventable childhood diseases.

• Fewer than half of the infants and toddlers in urban areas are fully immunized, and the majority do not begin school having had appropriate vaccinations.

• In 1991, 26.3 million children (40% of children younger than 18) lacked employer-backed health insurance (75–80% for Black and Latino children), and 8.3 million children were wholly uninsured.

• Low-income working families experienced a 25% decline in the availability of health insurance from 1977 to 1987.

Family Trends

• The United States has the highest divorce rate in the world, with about one-half of all marriages ending in divorce. (The majority of these involve children.)

• In 1959, 91% of all children lived in families headed by a married couple; in 1992, this percentage was 74%.

• In 1991, the poverty rate in female-headed, single-parent families was 55%, more than five times that of married-couple families.

Education

• Despite improved parental education levels, the academic performance of American children has not improved markedly in the past decade; test scores lag behind those of students in many other industrialized countries.

• During 1987, almost 2.5 million thefts and about 465,000 violent crimes occurred in and around schools.

Child Care

• About 10 million children younger than 5 were cared for by someone other than a parent in 1990.

• In 1991, 53% of women with an infant younger than 1 were in the labor force.

• About 1.3 million children age 5 to 14 care for themselves during the hours when they are not in school.

• The average number of children per child care staff member has risen by 25% since the 1970s.

• Adjusted for inflation, child care teacher salaries declined by nearly one quarter from 1977 to 1988, with more than half earning less than the poverty level for a family of three.

• 41% of child care workers left their jobs in 1988.

Child Welfare

• There are currently 2.7 million reports of child abuse and neglect per year.

• In 1991, approximately 429,000 children were in foster homes, group homes, or institutional settings, up from 270,000 in the early 1980s.

• One in five 3- to- 17- year-olds is reported by parents to have had a developmental delay, learning disability, or behavior problem during their childhood.

• In 1989, 12% of all children younger than 18 suffered from a mental disorder, and nearly half of them suffered serious emotional disturbances. Less than one third of these children get the help they need.

Needs of Children and Families

Basic Needs for Healthy Development

From the time of conception to adulthood, a child's development is determined by an enormous array of factors. Some of these factors are intrinsic to the child, and some are the result of familial and societal influences. Optimal development, regardless of whether it is physical, cognitive, social, or emotional, demands caregivers who are responsive to the needs of the child and have the resources to respond to those needs. Thus, from conception to birth, parents must have the health and emotional resources to foster the optimal growth of the fetus. Similarly, during infancy and childhood, caregiving adults must recognize what the developing child needs and have access to appropriate resources to fulfill these needs.

All children need to grow up in circumstances in which they are supported and valued by adults and peers, and challenged to develop emotionally, socially, and educationally. All children also need to live in environments in which their individual differences are understood and responded to with sensitivity. Mutually supportive interactions between children and family members provide the basis for positive emotional, social, and cognitive development when characterized by warmth, structure, and consistency.

Thus, a strong family system can lead to the development of an in-

dividual who is productive, self-assured, and socially competent. Given that family systems serve a primary role (together with schools) in nurturing and socializing children, they represent the most essential ingredient for the optimal growth and development of children.

Current Status of Children and Families

Numerous social, demographic, and economic factors have served to weaken the ability of families to provide healthy and developmentally appropriate environments for children. Poverty and economic instability, for example, cause some families to exist in conditions of inadequate nutrition, substandard housing, crime and violence, and social isolation. A growing number of children and youth experience the effects of poverty, along with the related and cumulative risks of poor physical health, low educational attainment, and psychological disorders. More children are also homeless, hungry, and without appropriate physical and mental health care.

Also, changes in family structure associated with increased divorce rates and the emergence of alternative family life-styles have resulted in more single-parent, step-, blended, gay, lesbian, and foster families, as well as decreased access to members of the extended family. The increase in the number of single-parent families and families in which both parents work, even when not economically disadvantaged, may result in increased stress and diminished functioning of the family system. Many children receive a substantial portion of their primary care from someone other than their parents, and access to adequate, high-quality, affordable child care is limited.

While these changes in family structure and work patterns may be positive for the family as a whole (e.g., increased income, career satisfaction), their effects on the development of children may not always be beneficial. An important perspective in this regard is not to blame families for potential problems associated with these changes.

but rather to acknowledge the existence of such problems when they do arise and consider more supportive and appropriate programmatic interventions. Restructured family systems can be empowered by effective support strategies, but existing family support systems that work in isolation (e.g., health care, schools, recreation, social services) are proving unable to meet the challenges presented by the changing demographics of society. Indicators of unmet needs of children include unacceptable rates of infant mortality, low birth weight, lack of immunization, child abuse and neglect, psychological disorders, violence and aggression, and substance abuse, to name but a few. Programs designed to support children and families appear overwhelmed by the magnitude of these (and related) problems, and seem unable to mobilize integrated, effective intervention efforts on behalf of children and families.

An Integrative Perspective on Child and Family Needs

The Role of Family Support Systems

The needs of children and families must be understood from an integrated, system perspective. The welfare of children is highly interrelated to their families' well-being. Moreover, families, irrespective of culture or social class, cannot be separated from the broader social systems within which they are embedded. These major systems include informal support systems (e.g., friends, neighbors, and relatives), in addition to institutional sources of support and assistance, such as those relating to health, education, employment, religion, recreation, housing, and social welfare.

Under optimal conditions, these systems should provide a supportive and responsive network of interactions and services on behalf of children and families. In this context, even children and families with numerous personal assets (e.g., a strong extended family, adequate economic resources) will need access occasionally to effective preventive and specialized services. Thus, the scope of an integrated, effective service system should range from ensuring healthy

development through prevention-oriented programs to early identification and treatment for children and families experiencing severe difficulties. The importance of healthy, responsive, and effective social systems to the optimization of child development and family life cannot be overestimated.

An integrative perspective should guide efforts to establish an empowering, healthy climate for children and families within the community at large. Such a view acknowledges the complex, reciprocal interaction among social systems, including families, when problems are conceptualized and service systems are designed. It assumes that children and families are most likely to benefit from collaborative, focused efforts among the various systems responsible for addressing their needs (both formal and informal).

In this regard, there are two essential social systems with which virtually all children and families have routine, significant contact: school and health care settings. The school is an environment wherein children engage in academic learning and growth, but also experience social and emotional interactions with adults and peers to build self-esteem and social competence. These experiences can serve to increase later prospects for success in relationships, the workplace, and personal pursuits. Thus, it is vital that schools support the broad developmental needs of children and families. However, schools are being asked to address the needs of children and youth at a time when fundamental transformations of schooling structures and outcome expectations are also being demanded. Restructured schools alone cannot satisfactorily address the multidimensional needs of children and youth. Schools and other child- and family-service organizations must collaborate to enhance the likelihood of educational and personal success for all children.

Many children and families receive their health care in primary-care settings, such as physicians' offices, community-based clinics, and other public health settings. These settings may be viewed as normal points of entry for the prevention, as well as the assessment

and treatment, of a host of physical and psychological problems. However, health care systems currently are strained, and many children have access to them only on a crisis basis. These systems also require collaboration with other services in order to address the developmental needs of children and families in a comprehensive and preventive manner.

Why Needs Are Not Being Met

There is an emerging consensus among professionals and consumers that the current service delivery system is not meeting the needs of children and families, and that solutions must go beyond adding resources (e.g., more funding, more programs) and toward fundamental changes in how the system operates. Social and political institutions have not considered the needs of children and families as funding priorities. Moreover, service delivery is often conceptualized from the point of view of professionals and may not be based on family perceptions of need. Individual service delivery systems for children (e.g., health care, education, social service, mental health) are funded and designed to address isolated and crisis-oriented needs, rather than to promote healthy development for all children and families in a comprehensive fashion. In addition, some parents either have no knowledge of how to gain access to available services or may not value them. Thus, services provided to children and families frequently are not comprehensive, responsive, or integrated.

Psychological services are also subject to the service delivery problems listed above. Inadequate psychological services result from limitations within the profession, as well as from systemic problems. For example:

- Psychologists may be trained in subdisciplines with limited knowledge of the activities and skills of related subdisciplines.
- Psychologists are not always trained to collaborate effectively with medical, educational, and social service personnel.

• Psychological personnel may be funded for narrowly defined tasks (e.g., diagnosis of behavior problems in teacher-referred children), greatly limiting a coordinated response to child and family needs.

• A narrow focus on territorial (e.g., protecting one's "turf") and guild-related (e.g., eligibility for reimbursement, credentialing) issues may foster attitudes that are not conducive to the development of integrated services for children and families.

• Political and organizational leaders who plan service delivery systems often are not familiar with the skills that psychologists can bring to the development of effective systems.

• Insurance reimbursement policies often determine eligibility for services and who is approved to provide them.

Thus, key sources of difficulty in the current service delivery system are lack of clarity, lack of coordination, and lack of comprehensiveness, resulting in inflexible patterns of funding, training, and service provision. The cognitive, social, emotional, educational, and physical needs of children are complex. An integrated services model provides for a more coherent, needs-based response to these complex problems.

Elements of Service Integration

Although there may be agreement among parents and professionals, that, as a whole, the current service system for children and families is fragmented, uncoordinated, and inadequate, there is no universal agreement regarding the features of a more comprehensive, coordinated, and effective system. Substantial literature has been generated to describe features thought to be indicative of a more responsive system, and these reflect the values and perspectives of various individuals, families, professionals, and organizations.

Because it is unlikely that any one definition of integrated services will suffice to include the full range of programmatic possibilities, there is a need to clarify the concept and make it operational. A review of the extant literature on integrated services has resulted in a consensus definition that will serve as the basis for policy recommendations.

Definition of Service Integration

The efficacy of services to children and families can be viewed from the perspective of the families themselves. When examined in this manner, emphasis is placed upon the nature of service delivery events or episodes that occur and the impact these events have on children and families. Within a well-integrated program, typically:

• Services are available in close proximity and are accessible without reference to physical, psychological, social, linguistic, sexual orientation, or other barriers.

• Services are comprehensive and appropriate, in that they possess features that address priorities the family has identified, at a level of service sufficient to their needs.

• Services are formulated and delivered at a high level of quality such that the family perceives them as an organized whole and can participate in them in a consistent and effective manner.

• Services serve to promote psychological competence and self-sufficiency rather than focusing exclusively on dysfunction and pathology.

• Services are oriented toward full participation, partnership, and empowerment of family members.

• Services are sensitive to cultural, gender, racial, linguistic, class, disability, and sexual orientation issues.

• Interventions are driven by concern for the needs and desires of the consumers (i.e., children and families) and emphasize explicit outcomes stated in a positive manner.

Features of an Integrated Service System

Relative to the definition offered previously, there is a continuum of integrated services that varies as a function of need, service availability, problem severity, and related dimensions. From the perspective of children and families, many opportunities and services can best be accessed through a single provider and implemented in an integrative manner. An integrated services model also assumes that the greater the number of providers involved (e.g., psychologists, nurses, teachers, social workers, physicians, day care workers), the greater is the need for effective collaboration. Timely and responsive interventions on behalf of children and families therefore rely on effective communication, coordination, and collaboration among ser-

vice providers, agencies and organizations, and the consumers of services (children and families).

Thus, **coordinated and collaborative services** should be the essential standard by which effective services are delivered. The service system must respond to the multiplicity of needs exhibited by children and families through carefully orchestrated teamwork. At a minimum, this takes the form of different providers (from independent agencies) communicating regularly by phone regarding a child or family. Or, it may involve regular face-to-face meetings and case conferences among providers. In the ideal, providers and family members would work as an integrated team to provide needed services. The net result of the integrated team concept could be service delivery models such as "one-stop shopping" or more staff sharing and program development activity.

In an uncoordinated system, families, individual providers, and agencies share some aspects of their work with each other, but essentially maintain their own sets of goals, expectations, and responsibilities in providing services to children. By contrast, the hallmark of collaboration involves families, providers, and agencies working with one another, establishing shared goals, mutually developing intervention plans, sharing responsibility for the implementation of those plans, and collaborating on assessing outcomes.

The service delivery system should also allow for both **ease of entry and flexibility of movement.** For example, if the point of initial contact in a community is a school setting, there should be a clear connection between the school and the array of community services that the family needs, regardless of categorical restrictions. This requires that individual providers and agencies see themselves as part of a much larger ecology that is communitywide and geared to aiding the overall climate within which children grow and develop. The point of initial entry into such a system should be less critical than the fact that child and family needs are considered paramount in responding to the concerns presented. The flexibility-of-

movement concept allows for a child or family to enter such a system at any point and move flexibly between services as their needs dictate, without having to confront barriers.

The service delivery system must be organized both **for maximum development of the child and for accountability,** first to the family and then to the community in which the child lives. This means that providers need to be retrained within a consumer-oriented model, with children and families seen as customers with whom one must collaborate, rather than as patients or adversaries. Community accountability refers to concern for improving the quality of life in communities through community resource development, advocacy, and related activities.

Funding for coordinated and collaborative services needs to be both flexible and shared (where possible) among agencies, such that different agencies can be encouraged to jointly develop programs that serve children and families holistically. Funding and program decisions need to be made from the "bottom up," and those providers who have ongoing contact and communication with the family should be the major decision makers about how "pooled" or "flexible" funds can be utilized most effectively, with direct input from the consumers of services.

Interdisciplinary interaction and training for providers needs to be a top priority in an integrated service model. It will be necessary for providers from different disciplines to know what other disciplines can contribute to solutions for issues confronting families. Collaborative effort outside of traditional disciplinary lines creates opportunities for true communication and integration among providers.

Some **organizational features** of integrated service approaches follow, as a means of providing a focus to consideration of this service delivery model. These features are expressed in the form of leading questions about programs and practices:

• Does the organization offer more than one type of professional service to the same child/family?

• Is more than one organization offering services to the same child/family? Are these efforts coordinated in an explicit manner?

• Does the organization have a functioning pattern that is flexible enough to support the coordination of an intervention program through intra- and interagency collaboration?

• Are there established internal procedures that encourage, facilitate, and support two or more service providers to work cooperatively on behalf of the child and family?

• Are resources, including funding, allocated based on needs of the child and family, rather than determined by categorical (e.g., diagnosis) or programmatic (e.g., placement) considerations?

Illustrations of Service Integration

Vignette 1. A child is identified as having behavior problems (e.g., poor grades, noncompliance, acting out) in school and is referred to the community mental health center for counseling. The Department of Social Service has also been involved with the family because of an earlier report by the school of potential abuse. At school, the child is referred for a special education evaluation, but it is determined that he does not have an educational handicapping condition.

Within an integrated services model, when the child was identified by the teacher as beginning to experience behavior problems, a meeting was held with the family, social worker, and psychologist present. At this time, an alliance was formed in which the family's perspective on the problem began the discussion of needs and issues. It was learned, for example, that the family was experiencing a higher level of stress due to economic factors, a death in the family, and marital discord. On the basis of this information, a child and family service plan was derived in which program elements were targeted to ameliorating family stress (e.g., procuring child care), coping with

grief (e.g., grief counseling), mental health counseling, and parenting skills training. Additionally, the parents, teacher, social worker, and psychologist agreed to collaborate on the development and implementation of a plan to manage the behavior of the child at home and in school and to teach social process skills. The group agreed to meet periodically to coordinate the implementation of this plan.

Vignette 2. A teenager with a new infant living in poverty is at high risk for dropping out of school and maltreating her child. Within a nonintegrated approach, this adolescent might receive a short-term counseling intervention from the health care setting. Greater services integration might involve (a) well-baby care, (b) parenting training, and (c) day care so that she could continue her high school studies. These services have important implications with respect to (a) the future illness or lack of readiness for school on the part of the child, (b) child abuse or neglect, and (c) facilitating the mother's future employability and adjustment.

Relevance to Psychology

Role of Psychologists

Psychologists should seek to develop systems that will ensure the healthy development of children and the strengthening and empowerment of families. In both primary health care and school settings, psychology can play an integral role in **advocacy, prevention, consultation, assessment, and treatment** for children and families. Psychologists employed in other social service, mental health, and related organizational settings can also have considerable impact on the welfare of children and families through early intervention and treatment activities. In all settings, psychological services must be integrated with other necessary services and provided in a manner that does not artificially separate the physical, emotional, and social needs of children and families.

There are a number of integrated service efforts underway, many of which involve or are led by psychologists. For example, a large-scale project in Austin, Dallas, Houston, and San Antonio, Texas (partially funded by the Hogg Foundation), focuses on the coordination and delivery of an extensive array of health and human services through neighborhood schools. In the Memphis city schools, educational, mental health, and social services have been integrated within a "one-stop shopping" paradigm. The National Institute of Mental Health promotes the Child and Adolescent Service System Program (CASSP) initiative, designed to improve mental health services for

children with severe emotional disabilities by encouraging states to provide more comprehensive and coordinated services through interagency collaboration and coordination of services. The Robert Wood Johnson Foundation is extensively involved in improving systems of care for children with emotional and behavioral problems, in addition to health promotion. Other prominent foundations sponsor large-scale family support and integrated services demonstration projects in a number of states (e.g., Annie B. Casey Foundation, Pew Charitable Trust). Scattered across the country are numerous other projects and activities in this same vein (e.g., within Head Start and related early education programs). Emerging from these projects is evidence that integrated services can be effective, responsive, and cost efficient. Furthermore, there is a recognition of the need to extend these findings to the service system as a whole.

Implications for the Profession of Psychology

The concept of service integration has several implications for psychology as a profession. On a general level, integrated service models will increase the amount of broad-based services available to children and families, both by generating new funds and by freeing up funds now tied to rigid eligibility criteria. However, it also seems likely that psychologists will remain one of a number of eligible providers to deliver such services and therefore continue to be in competition with other professions to demonstrate their relevance and efficacy. Because decisions about service delivery are likely to be outcome oriented, consumer driven, and cost conscious, the particular strengths of our profession (including its conceptual underpinnings, empirical base, and concern for assessing outcomes) are likely to flourish in such an environment.

It must also be acknowledged that alternative, less costly approaches to addressing child and family needs will increase within an integrated services approach. Thus, while a child problem might pre-

viously have been conceptualized exclusively within a traditional psychotherapeutic approach, in this integrated approach the psychologist might appropriately collaborate with a "big brother/big sister" or foster grandparent to meet the needs of the individual.

As integrated services become more prevalent in child and family service systems, a number of implications for psychological training, practice, leadership, and research are apparent.

Training. Services integration has major implications for both graduate and in-service training of psychologists in the direction of greater breadth and flexibility. A psychologist who is serving as the only mental health professional in an elementary school or public health clinic, for example, will need to be competent in a broad number of skills and approaches, ranging from typical developmental concerns and issues to guidelines for monitoring commonly used child psychotropic medications, family interventions, and community consultation. Professionals who are "generalists" in human services will have greater possibilities of employment in an integrated services system than those whose background is limited specifically to traditional psychological practice specialties. There will, of course, always be some need for specialization, particularly with respect to low-incidence or highly technical problems. Psychologists will need more systematic training in collaborative and consultation-based approaches to practice.

Practice. Psychological services within an integrated services framework will look and feel substantially different. Practitioners will be able to exercise greater flexibility in the range of activities in which they engage and will not be as constrained in regard to funding source and eligibility considerations. They will spend more time working as part of a team, in concert with a variety of providers, caregivers, and community members. They are likely to spend more time in home, school, and other community settings, in addition to working in consulting offices. And they will routinely work at the interdisciplinary boundaries among various social systems that im-

pinge on children and families, to coordinate activities, manage conflict, and ensure focus and quality of services.

Leadership. Psychologists should be trained and encouraged to assume leadership roles within integrated services programs. In addition to the more traditional aspects of program administration and supervision, leadership activities should focus on establishing an integrative strategic vision for child-serving organizations, building collaborative teams, and facilitating planned organizational change in the direction of more integrated services.

Research. Psychological research on the efficacy of integrated services delivery approaches for children and families represents a unique contribution for psychology. Such research is distinct from traditional controlled experimentation, in that the array of target problems is vast, treatment programs are diverse and multifaceted, and outcome measurement is complicated. Practicing psychologists need to become proficient in a broader range of methods and procedures (e.g., quasi-experimental design, multivariate analysis, program evaluation techniques, qualitative research) in order to conduct such social policy and program-related investigations. Psychologists would also be in a unique position to help service systems develop and validate information systems to allow for ongoing program monitoring and management.

The overall benefit of all of these changes is considerably greater effectiveness in the use of psychology to advance the public interest. There are at present large numbers of children and families whose needs in the areas of health, mental health, education, and social welfare are not being met. In addition to the personal cost to these individuals, the prosperity of the country suffers from their resultant inability to contribute fully as citizens. Psychology, in collaboration with other concerned persons and professions, has an opportunity to exercise the leadership necessary to secure effective, responsive, and comprehensive services for these children and families.

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APPENDIX A

Policy Statement of the American Psychological Association on Psychology and Service Integration

Whereas:

Economic, social, and demographic changes in America are dramatically affecting children and families, often resulting in greater stress and vulnerability to problems in living;

Children increasingly live in poverty and experience related social, physical, mental health, and educational problems;

Changing family and social structures often result in the need for prevention and/or intervention services for children at all income levels;

Sound mental health and psychological development for children result when basic developmental needs are met, families are intact and functional, and social systems support these needs;

All children and families can benefit from support, health promotion, and health education as they develop;

The needs of children and families must be viewed from a systems perspective—sound mental health cannot be separated from sound physical health, success in school, and healthy family and peer relationships;

Children and families have not been a funding priority for most social or political institutions; and

Services to children and their families are often inaccessible, limited, fragmented, and/or overlapping due to location, professional turf issues, prejudice and discrimination, restrictive funding, and poor linkages across systems.

Therefore:

APA calls for children and families to be placed as a priority on social and political agendas, including legislative, funding, service delivery, and research agendas.

APA affirms the importance of service integration to meet the comprehensive needs of children, including their psychological, educational, and mental health needs. Consequently, psychology must work collaboratively with other disciplines and across systems.

APA will work with other organizations to:

- promote policy and legislation that support comprehensive and coordinated services for children and families, including psychological services;
- explore implications of service integration for the training and roles of various disciplines, including psychology;
- develop and promote more flexible service delivery models and funding patterns; and
- promote research on the needs of children and families and on comprehensive and integrated models of service delivery.

APA will support federal, state, and local government, agencies, and schools in developing service integration models that meet psychological, educational, and mental health needs of consumers, with particular emphasis on the needs of children and families.

APPENDIX B

Integrated Services Programs Exemplars

Considerable efforts are already underway across the country (many led by psychologists) to implement the services integration paradigm in child-serving organizations. (A representative sampling follows.) All of the exemplars described below are targeted toward persons living in poverty or serve substantial numbers of economically disadvantaged persons.

Child Welfare/Social Services

Child welfare, juvenile justice, and mental health funds, in addition to private foundation monies (particularly from the Edna McConnell Clark and Annie E. Casey Foundations), are being used to support family preservation projects in numerous states and localities. In Michigan, the large-scale implementation of a family preservation program, called "Families First," is underway. In this program, public and private child welfare agencies collaborate to provide intensive, home-based, time-limited services to families with children who are at imminent risk for out-of-home placement. Modeled after the successful and much replicated Homebuilders program (Kinney,

Madsen, Heming, & Haapala, 1977), concentrated in-home and community-based services are provided by trained workers with small caseloads who are given programmatic flexibility and control of financial resources to meet family needs.

Iowa's Family Development and Self-Sufficiency Program aims to help high-risk AFDC families through support and education activities that include long-term employment services, a preschool program for at-risk children, targeted medicaid benefits, and transitional child-care for those leaving the program. Hawaii sponsors a multidisciplinary Family Support Systems' Healthy Start Home Visiting service that provides screening, crisis intervention, parent training, respite care, male home visitors for fathers, and toy-lending libraries (National Commission on Child Welfare and Family Preservation, 1990).

Health Care

High rates of pregnancy, sexually transmitted disease, drug use, mental illness, and mortality among adolescents require comprehensive and integrated responses, allowing for linking of services across different health domains and easy access to needed services. Thus, the Michigan Department of Public Health has established Adolescent Health Delivery Demonstration programs for health education, screening, case management, and referral. These are located in schools and other community settings and deliver both primary and preventive care. They blend state general funds with local and in-kind contributions, while also providing a billing system to access medicaid and other third-party payments. Multnomah County (Portland), Oregon, established school-based health centers in 1986, using a combination of state, federal, and local funding. Targeted toward providing comprehensive health care for adolescents and reducing teen pregnancy, the scope of services offered includes diagnosis and treatment of minor injury and illness, management of chron-

ic conditions, mental health services, health promotion activities, reproductive health, family planning, and AIDS education and prevention (Oomes & Owen, 1991).

In 1981, seven federal categorical maternal and child health (MCH) programs were consolidated into a single block grant, allowing states and municipalities discretion regarding MCH program development. Foci of the present program include (1) reducing infant mortality, preventable diseases, and handicapping conditions; (2) increasing immunizations and health assessments; (3) promoting maternal and infant health for low-income and at-risk individuals; and (4) providing preventive and primary health care to children and families. A wide variety of integrated services initiatives have occurred across the country within this program model, often in collaboration with other agencies and organizations (Association of Maternal and Child Health Programs, 1990).

Relatedly, the Robert Wood Johnson Foundation (RWJF) has demonstrated a long-term commitment to improving child and family health care, as exemplified by four large-scale, multisite demonstration programs. These include a program to consolidate health services for young people (through grants to 21 teaching hospitals for community-based projects), a school-based adolescent health care program, a mental health services program for youth, and an initiative to reduce the demand for illegal drugs and alcohol. An RWJF adolescent health care grant enabled Oklahoma, for example, to set up 12 rural adolescent health clinics in collaboration with maternal and child health and other community organizations (Oomes & Herendeen, 1989).

Mental Health Services

Within the National Institute of Mental Health, the Child and Adolescent Service System Program (CASSP) initiative, begun in 1984, promotes systems change in mental health services for children

with severe emotional disabilities by encouraging states to provide more comprehensive and coordinated services through interagency collaboration and service coordination (Day & Roberts, 1991). Initially funded through an RWJF planning grant in one region of the state (Bluegrass), Kentucky's IMPACT program represents a comprehensive, statewide restructuring of the system of care for children and adolescents with serious emotional disabilities. The program emphasizes collaboration among social service, education, mental health, and juvenile justice systems through state, regional, and local interagency councils, in addition to extensive case management, parent involvement, and flexible funding ("wraparound services"; Kentucky Cabinet for Human Resources, 1990). Initial evaluative information documents dramatic reductions in psychiatric hospitalization, accompanied by increases in social support to families and positive behavior change (Hilback, 1993).

In Ventura County, California, the Children's Mental Health Initiative, funded by the state legislature, used collaborative interagency planning to fill gaps in the prevailing service delivery array and develop some new services, with highly positive results noted in both child and family outcomes and cost efficiency (Jordan & Hernandez, 1990). In Fort Bragg, North Carolina, a longitudinal project seeks to demonstrate that coordination across the continuum of services and increased utilization of community-based alternatives can affect costs and treatment effectiveness, thereby making services available to more children and families (Heflinger, et al., 1991).

School-Based and School-Linked Services

The focus of school-based and school-linked services is to bring nonacademic services that support families and youth into school settings, the only institution with which virtually all children and families have contact. One of the provisions of the Kentucky Education Reform Act of 1990 was the establishment of family resource

and youth service centers at every school where at least 20% of the student body is eligible for free lunches (a measure of economic disadvantage). For the 1993–1994 school year, nearly 400 centers will be in place, providing school-based services such as before- and after-school child care, parent education and training, employment services, mental health counseling, and referral for medical, social, mental health, and family support services, in addition to more general community resource activities (Illback, 1992).

In the Memphis city schools, a broad range of educational, mental health, and social services has been integrated within a school-based mental health center, bringing together psychologists (clinical, counseling, school), social workers, substance abuse counselors, and paraprofessionals within a coherent and multidisciplinary program to serve children and families. In addition to traditional evaluation and treatment programs, the center provides teacher training, substance abuse counseling and support groups, social skills training groups, homemaker services, child abuse prevention programs, teen pregnancy programs, and a host of similar needs-driven efforts, all under the rubric of the school organization (Paavola, Hannah, & Nichol, 1989). Elements of service integration can also be found in Head Start, preschool, and related community action programs too numerous to describe here.

An effort sponsored by the Annie E. Casey Foundation is targeted toward at-risk youth in large urban areas, such as Bridgeport, Little Rock, and Pittsburgh. The program involves screening, developing multidisciplinary support teams, and case management, and seeks to improve attendance and graduation rates, increase youth employment after high school, and reduce adolescent pregnancy. In *School of the Future*, Holtzman (1992) describes an ambitious project (partly funded by the Hogg Foundation for Mental Health) in four Texas cities (Austin, Dallas, Houston, and San Antonio) to foster the coordination and delivery of an extensive array of health and human services through neighborhood schools. Community renewal, family

preservation, and child development are all cited as goals of this "one-stop shopping" approach to serving low-income families.

Mental Retardation/Developmental Disabilities

Integrated services programs for persons with mental retardation or developmental disabilities are often geared toward parent involvement, comprehensive skill training, adaptation, coping, and social and family support. Located in rural northwestern North Carolina, Project SHaRE (Source of Help Received and Exchanged) intends to help families with disabled, handicapped, and developmentally at-risk children to build and maintain social support networks. The program operates as a barter system in which individuals and groups provide assistance to one another based on reciprocal obligation. In addition to obtaining needed services, families become empowered and strengthened, and develop a greater sense of belonging in their communities (Dunst, Trivette, Gordon, & Pletcher, 1989).

Community-Based Collaboration

The Pew Charitable Trusts are sponsoring communitywide, longitudinal demonstration projects for families with young children living in communities where at least 30 to 40 percent are in or near poverty. Based on the development of a network of family centers, these projects will establish new forms of front-line practice with families and make key supports and resources available to them. The 10-year ventures (with matching foundation funds of $1 million to $2 million annually) are expected to document profound shifts in the health, education, and social service systems in their communities (Center for Assessment and Policy Development, 1992).

APPENDIX C

Suggested Reading

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APPENDIX D

Children's Mental Health Needs

Reform of the Current System

America's children suffer from an enormous unmet need for mental health services. Unfortunately, our present mental health delivery system wastes scarce mental health dollars. Congress should and can foster the healthy development of children and families by providing universal access to basic, affordable mental health care.

Need

Children need access to appropriate, high-quality mental health services.

- A March 1993 opinion poll highlighted the fact that an overwhelming percentage (73%) of Americans state that children's health and education are their number-one priority for the new administration.
- Over 14 million children are in need of outpatient mental health care.
- A 1990 study of private health insurance found that inpatient

adolescent treatment expenses increased by 65% between 1986 and 1988. Many of those hospitalized could have been treated more appropriately and less expensively on an outpatient basis if the health insurance reimbursement structure had allowed it.

• Children and families need access to appropriate, high-quality mental health care that includes prevention and early intervention, as well as treatment and crisis intervention.

• Mental health services should serve to promote psychological competence and self-sufficiency rather than focusing exclusively on dysfunction and pathology.

• Mental health services are already being provided by qualified personnel in schools and other settings; however, more mental health service providers are needed to address the extensive array of problems children and families now face.

Inadequacies of the Current Mental Health System

• At present, mental health services for children and their families are often inaccessible, limited, fragmented, or overlapping. Even though targeted at identical children's problems, funds from health, mental health, special education, juvenile justice, and child welfare agencies are often inflexible and uncoordinated.

• Indirect or preventive activities such as consultative services to parents, teachers, other school staff, and primary health care providers are often not reimbursable, despite the fact that such services are cost effective. Reimbursable services, such as medicaid, are often mired in bureaucracy and paperwork.

• For certain problems, such as child maltreatment, preventive approaches, which are generally not covered under health reimbursement structures, are obviously preferable to remedial treatment and are more cost effective. For example, parent training and in-home family support therapy that strengthens the family before any abuse

occurs is far better than the need for child protection services, foster care, legal involvement, and the disruption of family life.

Solutions

Children and families require universal access to comprehensive, coordinated, and high-quality mental health services designed to address their unique ethnic, cultural, and linguistic needs. These services should strike a balance between prevention, early intervention, and treatment modalities. They should be available across a range of community settings where children and families are traditionally served.

• *Build on the current school and primary health care systems.* A more broad-based system can be built using appropriately trained service providers in schools and other settings who can provide outpatient mental health care, including direct and indirect services, consultation, and in-service training. Within these natural entry points, these personnel are already in place, including psychologists, who can meet the physical, emotional, and social needs of this population in a coordinated, responsive manner.

• *Preventive services are key.* Preventive mental health services should also be covered under reform initiatives, just as immunizations should be covered for physical health. Health care reform should incorporate mechanisms to encourage, sanction, and fund the appropriate utilization of programs and providers in these settings.

• *Alternative services should be supported through flexible funding.* Examples of such service models include home-based clinical services; group therapy; "wraparound" programs, which provide comprehensive, individually tailored services; prevention; and family preservation initiatives. Such alternative approaches, which utilize

cross-disciplinary, cross-setting funding, have been shown to be effective and often less costly than traditional approaches.

• *Mental health services for children must be integrated.* Systems of care for children and families should be structured and funded to maximize coordination and interagency collaboration among child service providers and agencies. Such emphasis will allow for more integrated services that are accessible, comprehensive, consumer driven, outcome oriented, and focused on strengthening competence.

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Psychology in the Schools Program
Government Relations
Practice Directorate

APPENDIX E

Contributors and Reviewers

Evie Becker-Lausen, PhD
APA Congressional Fellow

Marva Benjamin, PhD
CASSP Minority Initiatives

Martin Blank
Institute for Educational Leadership

Richard Blocker
National Association of Pupil Services Administrators

Deborah Both
National Center on Services Integration

Deni Brancheau
American Art Therapy Association

Janine Breyel
National Governors' Association

Martha Bush
Council of Chief State School Officers

George Cohen, MD
American Academy of Pediatrics

Richard M. Cohen
American Psychological Association

Mary Crosby
American Academy of Child & Adolescent Psychiatry

Diane Doherty
CASSP Child & Youth At Risk

Isadora Hare
National Association of Social Workers

Nina Gail Levitt, PhD
American Psychological Association

Susan P. Limber, PhD
Society for the Psychological Study of Social Issues and Fellow, Amerian Psychological Association

Carolyn Marzke
National Center on Services Integration

Linda McCart
National Governors' Association

Sandra McElhaney
National Mental Health Association

John H. Meier, PhD
San Bernardino Preschool Services Department

Carol A. Neiman
American School Counselor Association

Russ Newman, PhD, JD
American Psychological Association

Joseph Palombi, MD
American Association of Psychiatric Services for Children

Cassandra Peters-Johnson
American Speech-Language-Hearing Association

Darlene Pierce
American Association of School Administrators

Annette Rickel, PhD
APA Congressional Fellow

Cheryl Rogers
Center for the Study of Social Policy

Sylvia Rosenfield, PhD
University of Maryland

Mary Alice Schreiter
National Council of Community Mental Health Centers

Pat Schwallie-Giddis, PhD
American Counseling Association

David G. Shaw
American Public Welfare Association

Milton Shore, PhD
American Orthopsychiatric Association

Rick Jay Short, PhD
American Psychological Association

Julie Shroyer
American Psychiatric Association

Tracy Stern
National Health and Education Consortium

Candace Sullivan
National Association of State Boards of Education

Carole King Sullivan
American Academy of Pediatrics

Megan C. Sylvester
Child Welfare League of America, Inc.

Deborah Tharinger, PhD
University of Texas at Austin

Virginia View
Zero To Three/National Center on Clinical Infant Programs

Claudia Waller
American Association of Children's Residential Centers

Ralph Wenger, PhD
Chapel Hill-Carrboro City Schools/University of North Carolina at Chapel Hill

Kaye Whitley, EdD
American Counseling Association

Brian Wilcox, PhD
American Psychological Association

Sandy Wurtz
National Council of Community Mental Health Centers